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AN EXPLORATORY STUDY OF NURSES' AND PATIENTS' PERCEPTIONS OF THE BAD PATIENT

by

Reeda Ramick Owens
B.S., Washington University, 1957

A Thesis submitted to the Faculty of the Graduate School of the University of Colorado in partial fulfillment of the requirements for the Degree

Master of Science

School of Nursing

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This Thesis for the M.S. degree by

Reeda Ramick Owens

has been approved for the

Department of

Nursing

by

Margaret A. Berry

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Date 7/27/64

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The writer wishes to express her appreciation to the members of her thesis committee, Assistant Professor Margaret Berry, Associate Professor Edith Olson, and Associate Professor Maxine Berlinger, for their support and guidance throughout the entire study.

To the patients and nurses whose participation was essential to the collection of data I am sincerely grateful.

Owens, Reeda Ramick (M.S., Nursing)

An Exploratory Study of Nurses' and Patients' Perceptions of the Bad Patient

Thesis directed by Assistant Professor Margaret Berry

The problem of this study was to gain information about the bad patient and how the nurse perceives this individual. The information studied was: (1) the nurse's perceptions of the bad patient, (2) the patient's perceptions of himself, and (3) the nurse's and patient's perceptions of the ideal patient.

The instrument developed to obtain data was a Q-sort. Literature pertaining to the bad and ideal patient was utilized in the development of the fifty items in the sort. Ten patients and thirteen nurses performed the sorts requested.

The data obtained from the sorts were converted into mean scores for the individual items and a Pearson product-moment correlation coefficient was used to determine statistically the strength of agreement between the mean ratings for each pair of the sorts.

It was concluded that both nurses and patients see the ideal patient similarly and the patient sees himself like the ideal patient. Nurses indicated they perceived the bad patient differently than they did the ideal patient although they had some understanding of the

feelings of the bad patient. The patient saw himself significantly closer to the ideal patient than did the nurse. It was also concluded that the patients identified as bad also had a diagnosis of a chronic illness and had prior opportunity through previous hospital admissions to become familiar with the patient role.

This abstract of about 210 words is approved as to form and content. I recommend its publication.

Signed Margaret A. Berry
Instructor in charge of thesis

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CHAPTER I

THE PROBLEM AND DEFINITIONS OF TERMS USED

The individual who is admitted to the hospital enters an environment which Rose Coser has called "a home away from home."[1] This home provides all the modern medical and technical facilities and personnel necessary for his recovery. Along with these modern miracles the hospital can also cause frustration, anxiety, boredom, and loneliness.[2]

The individual's reaction to this environment is focused on his primary obligation within the patient role. This obligation demands that the individual concentrate his activities on recovery and return to a level of wellness.

Each person who is hospitalized has brought with him a different background and personality structure. Within the framework of his past and present experiences the patient will react to the hospital in his own unique way. However his reactions all focus on his primary obligation--to get well.

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[1] Rose Laub Coser, "A Home Away From Home," Sociological Studies of Health and Sickness, Dorrian Apple, editor (New York: McGraw-Hill Book Company, Inc., 1960), p. 154.

[2] Esther Lucile Brown, Newer Dimensions of Patient Care Part I: The Use of the Physical and Social Environment of the General Hospital for Therapeutic Purposes. (New York: Russell Sage Foundation, 1961), pp. 20-25.

Personnel working within the hospital culture have expected patients to react to the hospital environment within this frame of reference. Nurses, by virtue of their constant and lengthy contact with patients, have utilized this concept in making judgments about a patient's pattern of behavior in his struggle to regain health.

The nurse's role is such that she is expected to utilize her skill, abilities, and knowledge to help the patient achieve his obligation. Patients whom she sees as working with her in fulfilling this obligation are judged by her to be a cooperative, good patient. Most patients fortunately accept and fulfill the obligations of the patient role and are judged in the above manner.

However in some situations the nurse finds herself forced to cope with the individual who "despite a need for bed rest, medications, diets, and other therapeutic regimens, refuses to follow the treatment plan prescribed for them."[3] Another individual may refuse to meet his obligation by having complaints and incapacity out of proportion to his illness. He makes numerous little demands for help from hospital personnel and is prone to make frequent complaints and criticism about his care.

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[3]John C. Nemiah, "The Nurse-Patient Relationship In A General Hospital," Mental Hygiene, XLVIII (April, 1964), p. 180.

These individuals who do not conform to the nurse's concept of the patient role are often labeled as uncooperative, a problem or a bad patient.

The nurse in her attempt to care for these individuals is continually frustrated in her efforts to assist the patient to meet his obligation.

I. THE PROBLEM

Statement of the problem. The problem of this study was to gain information about the bad patient and how the nurse perceives this individual. The information studied was: (1) the nurse's perceptions of the bad patient, (2) the patient's perceptions of himself, and (3) the nurse's and patient's perceptions of the ideal patient.

Purpose of the study. The purposes of this study were: (1) to determine whether a difference exists between characteristics ascribed to the bad patient by the patient and by the nurse; (2) to determine whether the variables of age, sex, diagnosis, and length of hospitalization are similar among bad patients; (3) to identify the differences, if any, between characteristics ascribed to the ideal patient by the bad patient and by the nurse; and (4) to identify the differences, if any between the characteristics ascribed to the bad patient and the ideal patient by the patient himself.

Justification for the problem. Continuing emphasis on the nurse-patient relationship as a therapeutic tool has made it relevant that a study be made of the relationship between the nurse and the bad patient.

If the nurse has continually felt frustrated in caring for these patients it can be assumed that the care she has given these patients has been affected.

> Nurses may refuse special requests to avoid spoiling patients, may stay away from difficult patients except when they have to approach them, or may use approval or disapproval to reward good patients and discourage bad patients.[4]

Nemiah has stated that:

> in managing such [bad] patients it is very important not only that the nurse have knowledge of the nature and structure of the . . . reaction, but that she be aware of the feeling that these patients arouse in her, . . .[5]

Some studies have been done concerning the attitudes of nurses toward the bad patient but the investigator discovered none which attempted to see how the patient and the nurse perceived the bad patient.

The technique, Q-sort, used in this study provided a means of more objectively studying the perceptions of the patient and the nurse. The Q-sort placements made

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[4] Ruth V. Matheney and others, Fundamentals of Patient-Centered Nursing (St. Louis: The C. V. Mosby Company, 1964), p. 97.

[5] Nemiah, op. cit., p. 184.

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by a group of patients and a group of nurses were compared and correlation coefficients obtained.

Limitation and scope of the problem. The data collected in this study was obtained from a voluntary, general hospital with a capacity of 425 patients. The patients were chosen from the eight medical-surgical units in the hospital excluding the intensive care units and the graduated care pavillion. Whether there would be similar findings in other hospitals and settings was beyond the scope of this study.

Participants in this study were limited to ten patients and thirteen nurses. The technique used to collect data, Q-sort, limited the amount of information gained by virtue of its forced-choice construction.

II. DEFINITION OF TERMS USED

Nurse. In this study "nurse" will refer to a registered professional nurse functioning as a member of the hospital staff engaged in the care of patients.

Bad patient. The term "bad patient" will indicate an individual whose behavior is judged to be unacceptable by nurses and who is said to interfere with the effective and efficient execution of hospital procedures.

Ideal patient. The term "ideal patient" is interpreted to mean an individual whose behavior is

judged to be highly acceptable by nurses and who enhances the effective and efficient execution of hospital procedures.

III. ORGANIZATION OF THE REMAINDER OF THE THESIS

In Chapter II pertinent literature on the perception of the patient role by the patient and the nurse and the reactions of the patient to the hospital environment and his illness will be reviewed and summarized. Chapter III presents a description of the methodology, the tool, and the procedure for the study. The analysis and interpretation of data will be found in Chapter IV. The summary, conclusions, and recommendations based on the findings are included in Chapter V.

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CHAPTER II

REVIEW OF THE LITERATURE

In Chapter I the problem of the study and the definitions of terms used were presented. This chapter is devoted to a review of literature in the fields of nursing, medicine, and the behavioral sciences pertinent to the problem.

An attempt was made to explore the patient role in the hospital and the various factors which could influence the patient's behavior. Through the review of literature previous studies related to the nurse's attitudes and behavior toward the problem patient were explored. Literature regarding methodology and analysis was reviewed and presented in Chapters III and IV.

I. THE PATIENT ROLE

To understand the behavior of a patient it was necessary to look at what is expected of the individual when he assumes the patient role in the hospital setting. Also of importance was the effect of the hospital environment on the patient.

Talcott Parsons has defined the sick role within the context of our culture. The specific features of this role were: (1) a legitimate basis for exemption

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of the sick individual from his normal role, (2) an obligation to try to get well and to cooperate with others to this end, and (3) to seek competent help and to cooperate with competent agencies in their attempts to get him well.[1] Within our culture the hospital has been designated as the agency for the sick person, unlike other cultures where the home remains the environment for the ill.

Simmons has stated that the culture of illness in the home is quite different from that of the hospital. The home provided a fortress of security for the patient and there he retained his rights and privileges and was the center of attention. The hospital culture of illness contrasted with this by causing dread and apprehension, dependence on unfamiliar things and people, and attention to many ill individuals.[2]

Brown when writing of the hospital environment and the expectations of patients stated that:

> Persons who have been accustomed to living in this kind of psychological environment [the home] are likely to have difficulty in adjusting to the average general hospital where the patient may well consider himself unnecessarily robbed of

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[1] Talcott Parsons, "Definitions of Health and Illness in the Light of American Values," Patients, Physicians and Illness, E. Gartley Jaco, editor (Glencoe, Illinois: The Free Press, 1958), pp. 176-177.

[2] Leo Simmons, "The 'Culture of Illness' in the Home Versus the Hospital," (in Part I of Newer Dimensions of Patient Care, ed. Esther Lucile Brown. New York: Russell Sage Foundation, 1961), pp. 121-125.

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> independence and opportunity to make decisions for himself; where care is provided largely, if not almost entirely, on the basis of impersonal procedures and orders; and where formal rules and regulations determined on the higher administrative levels are applied wherever possible to the entire hospital.[3]

The patient's view of the patient role was explored by Mauksch and Tagliacozzo. Findings indicated that patients felt they "should be cooperative, considerate of others, not demanding and not dependent."[4] Deviations from these standards were expected to result in disapproval. Conformity to these role obligations were facilitated when:

> (a) the behavior demanded by the role of the hospitalized patient does not come into conflict with personality needs of the patient, (b) behavior appropriate to the patient's other social roles is not incompatible with the behavior expected during hospitalization, (c) the patient's trust and confidence in physicians and nurses can check his anxieties and fears, and (d) the patient has a relatively clear understanding of the nature of his illness and the meaning of care and cure procedures.[5]

Coser used Parsons' analysis of the sick role in a study of patients in the hospital situation. She gave

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[3] Esther Lucile Brown, Newer Dimensions of Patient Care (Part I: The Use of the Physical and Social Environment of the General Hospital for Therapeutic Purposes. New York: Russell Sage Foundation, 1961), p. 29.

[4] Hans O. Mauksch and Daisy L. Tagliacozzo, The Patient's View of the Patient Role, Department of Patient Care Research, Presbyterian-St. Luke's Hospital, Part I (Chicago: Presbyterian-St. Luke's Hospital, 1962), p. i.

[5] Ibid., p. ii.

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three conditions imposed on the patient. These were that the patient:

> (a) forfeit his reliance on family and friends in the matter most important to him at the moment, his health. . . . (b) accept the 'routine' and 'order' of the hospital as defined by nurses and doctors and that he accept the hospital setting as is. . . . (c) attempt to be a 'good patient.' This means, in terms of doctors' and nurses' expectations, that he not complain, that he submit to rules and regulations without making any personal claims.[6]

Coser also found that the orientation of the patient toward the hospital or doctor seemed to be associated with his adaptation to the sick role. The patient who submitted to the conditions imposed on him was termed a "good" patient. Also inherent in the sick role as defined in this study was the necessity of abandoning it and those individuals who refused to get better were termed "bad" patients.[7]

II. FACTORS RELATED TO PATIENT BEHAVIOR

Numerous factors have been studied as they appear to influence the behavior of patients in the hospital setting. The writer wanted to know if there were certain variables which might influence the nurse in labeling a

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[6] Rose Laub Coser, "A Home Away From Home," Sociological Studies of Health and Sickness, Dorrian Apple, editor (New York: McGraw-Hill Book Company, Inc., 1960), p. 158.

[7] Ibid., pp. 154-177.

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patient as bad.

Chase, using Q-sort methodology, found that maladjusted and adjusted patients perceived their ideal selves and the average other person similarly but the maladjusted patient saw himself more unlike the ideal and average other person than the adjusted patient.[8]

In a study of fifteen male patients who had lengthy and repeated hospitalizations Caliman found that a majority: (1) had excessive concern over their health, (2) were below average in maleness and masculinity, (3) had a low self-esteem, and (4) were not able to effectively control their emotions.[9]

Mauksch and Tagliacozzo explored sex and illness as factors affecting patient behavior. They found consistent differences between male and female patients. "Women appear to fear less that they themselves will be considered demanding and they seem more ready to consider themselves sick enough to expect service."[10] Differences between patients with cardio-vascular and gastro-

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[8]Philip Howe Chase, "Concepts of Self and Concepts of Others in Adjusted and Maladjusted Hospital Patients" (unpublished Doctor's dissertation, The University of Colorado, Boulder, Colorado, 1956).

[9]Alvis Caliman, "Personality Factors Related to Lengthy and Repeated Hospitalization," Journal of the National Medical Association, LIV (March, 1962), pp. 220-221.

[10]Mauksch and Tagliacozzo, op. cit., p. iv.

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intestinal diseases seemed significant. Patients with cardio-vascular diseases voiced criticisms less frequently and focused their behavior on cooperating with doctors and nurses. There was also evidence presented that:

> patients who do not experience active and well defined symptoms and whose activities are not visibly impaired may hesitate to present themselves to others as seriously ill and may find 'cooperation' at times more difficult.[11]

In a study of tuberculosis patients Wolf and Thurston reported that the behavior of eighty-seven per cent of patients who had irregular discharges were classified as difficult. These patients had: (1) underestimated their disease and the necessity for treatment, (2) a negative attitude toward hospitalization, and (3) difficulty in establishing friendships in hospitals.[12]

Ossenberg studied the effect of class differences on the hospitalization of individuals. He found that patients in a high social class had the highest amount of deviance in the patient role as compared to the middle and lower classes. These individuals had feelings of social isolation and unfavorable attitudes toward the hospital. They also had more general discomfort and

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[11] Ibid., p. 51.

[12] Joanne Wolf and John R. Thurston, "Relationship of Ward Behavior to the Discharge Status of Tuberculosis Patients," Nursing Research, VII (February, 1958), pp. 29-32.

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disvalued the patient role.[13]

Two studies showed the influence of age on the behavior of patients. Pollack, et. al., compared individuals over sixty-five years of age in institutionalized and non-institutionalized groups. The institutionalized group as a whole were more self-derogatory and the females more so than the males.[14]

An investigation of fifty patients labeled uncooperative by personnel in an out-patient department by Schwartz showed that almost half of the patients were diabetics and over half were from fifty to seventy-five years old. Common factors found in all of these patients were that: (1) all found it difficult to conform to accepted clinic routine, (2) all demanded attention in excessive amounts and required immediate gratification of requests, (3) most showed considerable aptitude for invalidism and bids for attention were made in awkward inappropriate ways, and (4) all exhibited ability to "needle" professionally prepared people.[15]

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[13] Richard J. Ossenberg, "The Experience of Deviance in the Patient-Role: A Study of Class Differences," Journal of Health and Human Behavior, III (Winter, 1962), pp. 277-282.

[14] M. Pollack and others, "Perception of Self in Institutionalized Aged Subjects," Journal of Gerontology, XVII (October, 1962), pp. 405-408.

[15] Doris Schwartz, "Uncooperative Patients?," The American Journal of Nursing, LVIII (January, 1958), pp. 75-77.

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In looking at patients who were labeled over-complainers Liber felt that these individuals suffered from fear and a lack of self-trust while the non-complainer felt secure and had no need to complain even when bothered by symptoms.[16]

In speaking of the regressive behavior of patients Brown stated that:

> fears, worries, loss of self-identity, discomforts, and deprivations, ennui, and embarrassment because of aspects of the physical care he must accept may all combine to reduce him to psychological childhood.[17]

It can be seen that a number of variables may influence the behavior of the patient in the hospital.

III. NURSES' ATTITUDES AND BEHAVIOR TOWARD BAD PATIENTS

Matheney, et. al., stated that "how a nurse feels about a patient or a situation can influence to a marked degree the quality of nursing care given."[18] A study by Morimoto of favoritism in personnel-patient interaction showed the above statement to be true. She found that:

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[16] Benzion Liber, "Noncomplainers and Overcomplainers," International Record of Medicine, CLXXI (April, 1958), pp. 243-246.

[17] Brown, op. cit., p. 24.

[18] Ruth V. Matheney and others, Fundamentals of Patient-Centered Nursing (St. Louis: The C. V. Mosby Company, 1964), p. 86.

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(1) personnel made more contacts and spent more time interacting with favored than with nonfavored patients, and (2) personnel gave as much attention to the physical needs of the nonfavored patient as to the favored patient. The author stated that "in a word, the nonpreferred patient is treated as a patient, while the preferred is recognized as a person."[19]

Spitzer and Sobel investigated the preferences of nurses for pediatric patients. They found that behavior which could be categorized as fulfillment of staff expectations was preferred and behavior indicating social immaturity was non-preferred.[20]

Gunter found in studying nursing care assignments for medical-surgical patients that nurses described the ideal patient to care for under a modest-self-effacing diagnosis.[21]

In a study to determine attitudes of nurses to patients Ritvo questioned fifteen hundred graduate and student nurses through interviews and questionnaires. All but eighteen or eighty-three hundredths per cent

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[19]Francoise Morimoto, "Favoritism in Personnel-Patient Interaction," Nursing Research, III (February, 1955), p. 112.

[20]Stephan P. Spitzer and Raymond Sobel, "Preferences for Patients and Patient Behavior," Nursing Research, XI (Fall, 1962), pp. 233-235.

[21]Laurie Gunter, "A Study of Three Types of Nursing Care Assignments," Nursing Research, XIII (Winter, 1964), p. 27.

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classified patients as good or bad. She found that the difficult patient had diametrically opposed characteristics of the good patient. The difficult patients were those whose social behavior was bad while the good patients were generally seen as cooperative, appreciative, and seriously ill. Student nurses and graduate nurses with human relations training seemed more accepting of the difficult patient.[22]

In the study by Schwartz mentioned previously she found that the individual staff member felt that the uncooperative patient "makes me feel ineffective."[23] They also felt that the patients were stubborn, would not recognize when help was given, were not appreciative, and that it was impossible for the staff to make the patient understand.[24]

In a study done by students at Duke University School of Nursing sixty nurses were asked to describe what characteristics influence their judging of a patient as good or bad. The good patient was seen as non-complaining and non-demanding, cooperative, and

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[22]Miriam M. Ritvo, "Who Are 'Good' And 'Bad' Patients?," The Modern Hospital, C (June, 1963), pp. 79-81.

[23]Schwartz, op. cit., p. 75.

[24]Ibid.

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appreciative, while the bad patient was described as the direct opposite.[25]

IV. SUMMARY

In this chapter the patient role, factors related to patient behavior, and nurses' attitudes and behavior toward bad patients were reviewed. The studies indicated that patient and nurse behavior was of significant interest and importance in the hospital setting. A number of investigators showed that nurses did have definite ideas of what constituted the good and bad patient. However, no studies which involved both nurse and patient in an objective, quantitative evaluation of how they perceive the good and bad patient were apparent.

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[25] Thelma Ingles, "Understanding the Nurse-Patient Relationship," Nursing Outlook, IX (November, 1961), pp. 698-700.

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CHAPTER III

METHODOLOGY

I. THE Q-SORT TECHNIQUE

The Q-sort technique was investigated to allow the writer to look at the perceptions of nurses and patients about the bad patient.

Stephenson advocated the Q-sort technique as a means to study the behavior, personality, interaction of man as both objective to others and subjective to himself.[1]

Block describes the Q-sort method as a technique to characterize a particular person. In the Q-sort method the judge or evaluator is given a set of statements or items previously developed or fixed upon. The set of items constitutes the entire vocabulary the evaluator is permitted to use. Conventionally the Q-items are printed separately on cards which permits convenience in the arrangement. The items are then put in order of significance for the individual.[2]

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[1] William Stephenson, The Study of Behavior (Chicago: The University of Chicago Press, 1953), p. 5.

[2] Jack Block, The Q-Sort Method in Personality Assessment and Psychiatric Research (Springfield, Ill.: Charles C. Thomas, Publisher, 1961), pp. 7-12.

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Whiting has described the use of Q-sort as a technique for evaluating perceptions of interpersonal relationships with a particular focus on the nurse-patient relationship. The kind of problems that Q-sort is designed to solve include the problem of correlation between different individuals' or different groups' attitudes, expectations, or opinions at a given time and the degree of change in individuals' or groups' attitudes or opinions from one time to another.[3]

In considering the use of Q-sort as a research technique Whiting gives several advantages. It is flexible in its use for gaining significant data. It is more amenable to experimental control than the interview by itself. The validity and reliability are increased since the examiner cannot distort the data. The method of assessment of attitudes and opinions is more penetrating than the questionnaire. It is less time consuming and so its administration is more feasible.[4]

Whiting also gives three disadvantages of the Q-sort method. Careless item writing will present the sorter with meaningless choices. The sorting is a very difficult and uncomfortable choice for the subject. A

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[3] J. Frank Whiting, "Q-Sort: A Technique for Evaluating Perceptions of Interpersonal Relationships," Nursing Research, IV (October, 1955), p. 70.

[4] Ibid., p. 71.

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third criticism is that the subject, depending upon the design, is sometimes required to condemn himself.[5]

In writing items for the Q-sort Stephenson gives the following principles to guide the writer. A universe of statements or items are written about some subject. The sample should be balanced and homogenous. To achieve this balanced design it is necessary to construct an item with a positive assertion or meaning for every item with a negative implication.[6]

The Q-sort items are then printed on separate cards. These items are then arranged into a designated ordering with an assigned number placed in each category. This type of sorting is termed the "forced choice" method. The prescribed distribution should be symmetric and is usually normal or Guassian although other distributions can be used.[7]

In the treatment and analysis of Q-sort data a number of approaches can be utilized. The two most common are: (1) the comparison of item placements in one Q-sort with item placements in another Q-sort, and (2) the comparison of Q-item placements in one group of

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[5] Ibid., p. 71.

[6] Stephenson, op. cit., p. 78.

[7] Block, op. cit., pp. 71-80.

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individuals with Q-item placements in another group of individuals.[8]

II. METHOD OF PROCEDURE

Approval for the study. A personal interview with the director of nurses was made to discuss the plans for the study. The director of nurses then contacted the hospital administrator for his approval. It was decided that approval from each patient's private physician would be necessary. A form letter to be included in the patient's chart was used to obtain this approval and is reproduced in Appendix A. Also included is the letter to the director of nurses asking permission to use the hospital for the study.

Construction of the instrument. Items for the Q-sort were taken from previous studies about the bad and ideal patient.[9] It was decided to utilize an adjective-adverb Q-sort rather than the more conventional form of neutral statements.

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[8] Ibid., pp. 89-90.

[9] Thelma Ingles, "Understanding the Nurse-Patient Relationship," Nursing Outlook, IX (November, 1961), pp. 698-700; Hans O. Mauksch and Daisy L. Tagliacozzo, The Patient's View of the Patient Role (Chicago: Presbyterian-St. Luke's Hospital, 1962), pp. i-iv; Rosemary Rich and James K. Dent, "Patient Rating Scale," Nursing Research, XI (Summer, 1962), pp. 163-171; Miriam M. Ritvo, "Who Are 'Good' and 'Bad' Patients?," The Modern Hospital, C (June, 1963), pp. 70-81; Doris Schwartz, "Uncooperative

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Fifty-four items were submitted to a committee composed of two nurses on the faculty of this school of nursing. They were asked to review the items for clarity and relevancy. Four items were questioned as to their clarity. These items were removed. Suggestions for rewording made by the committee were utilized.

The final fifty items included twenty items describing the ideal patient, twenty items describing the bad patient, and ten items which could describe either the ideal or bad patient.

The Q-sort items were typewritten onto 2" x 3" cards, one item to each card. The code number of the item was placed in the lower right corner of each card.

A forced choice distribution was used with a total of nine categories determined by a normal curve distribution. This conformity to the normal curve was basic to the statistics to be used for the analysis of data. The forced distribution used is shown in Table I.

Patients?," The American Journal of Nursing, LVII (January, 1958), pp. 75-77; Gertrud Bertrand Ujhely, The Nurse and Her Problem Patients (New York: Springer Publishing Company, Inc., 1963), pp. 1-180.

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TABLE I

NUMBER OF ITEMS IN EACH ROW

Number of items	2	3	6	9	11	9	6	3	2
Row number	1	2	3	4	5	6	7	8	9

Selection of subjects. The patients and nurses used in this study were selected from the population of the general medical-surgical floors, excluding the intensive care units and the graduated care pavillion.

To select patients for the study the investigator contacted the nurse in charge of the unit and asked her to indicate any patients which were considered to be problem patients by the nursing staff. Following this the investigator listened to morning report. Patients described by the nurses at this time as bad patients were listed. Patients that were mentioned by the charge nurse and were described in morning report as bad were included in the study.

Prior to the actual selection of patients the investigator tried the described method of selection of patients to determine its reliability and feasibility. The investigator used this method five times to select bad patients. Out of the two listings of bad patients

approximately seventy per cent of these patients were mentioned on both the charge nurses' list and the morning report list. The time required for selection was minimal. For these reasons the described method was used to select patients for this study.

Patients who by virtue of their physical incapacity or lack of reading ability in the English language were not included. Patients with a psychiatric diagnosis were omitted in the selection procedure.

The nurse population for the study was selected from each unit where the selected patient was hospitalized. The nurse in charge of the unit, usually the head nurse or assistant head nurse, was used to do one sort. The other nurse selected was the nurse directly responsible for the care of the selected patient.

Collection of data. Following the selection of the patient, the patient's private physician was contacted for permission to include the patient in the study. After the physician had given his written approval by signing the form-letter the patient was contacted for his inclusion in the study.

Patients were not informed that they were considered a bad patient by the nursing staff. If the patient was available at this time the sort was done; if not, the investigator returned at a time convenient

for the patient. Nurses were contacted individually and asked to do the sort. Appointments were made at their convenience.

Two sorts were done by all the subjects. Following is the description of the sorts as they were performed by the subjects. Patient-self--in this sort the patient sorted the items so that they described himself in the patient role. Patient-ideal--in this sort the patient sorted the items so as to describe the ideal patient. Nurse-patient--in this sort the nurse sorted the items to describe the specific bad patient. Nurse-ideal patient--in this sort the nurse sorted the items to describe the ideal patient.

Identifying information about the patient was collected from the patient's chart and from direct questioning by the investigator. This information included: age, sex, marital status, religion, education, residence, length of present hospitalization, and number of previous hospitalizations.

Nurses were requested to give the following identifying information: age, sex, religion, marital status, nursing education, date of graduation; and duration of employment in this institution and in their present position.

The physical setting varied so that it would be convenient for the subjects and would make for easy

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collection of data. The various settings were characterized by privacy, relative quiet, and a table large enough to do the sort.

Following the collection of the identifying data the subjects were seated at a table with the pack of shuffled cards. The instructions were given or read to the subjects. They are reproduced in Appendix D. Any questions concerning the mechanics of sorting the items were answered. There was no time limit imposed for the sorting. The time taken for the first sort ranged from eleven to twenty-five minutes and for the second sort from ten to fifteen minutes.

As each subject finished the first sort the cards were removed and the second pack was given to the subject. Instructions for this sort were then given. The cards were picked up by the investigator in such a way that they could be tabulated in proper sequence. This was accomplished by picking up the eleven cards most describing the patient first, the next three piles in order, and then the eleven cards least describing the patient. Tabulation on a data sheet was done immediately following each sort. (See Appendix C)

Procedure for validating the sort. A study was conducted to pretest the Q-sort instrument. Since the investigator had not administered this type of test

previously the study also served to check the method of administration. Another purpose was to find if the code number placed in the lower right corner of each card would be of concern to the individual or interfere with the placement of the card. If there were any other difficulties in the administration of the sort the study would point them out.

Four professional registered nurses were used in the study. The nurses were asked to sort for the bad patient with a one week interval between the sorts. A test re-test method was selected to obtain a correlation coefficient for the two sorts.

Pearson product-moment correlation coefficients were computed for each subject who performed the sort. The significance of the correlation between a set of paired observations can be tested by assuming the null hypothesis that the value of the correlation coefficient is equal to zero and then a test of significance may be applied using the distribution of t. Using this method a coefficient of 0.354 would have been significant at the 0.01 level of significance and a coefficient of 0.273 would have been significant at the 0.05 level. All the coefficients were above the 0.01 significance level.

TABLE II

TEST-RETEST CORRELATION COEFFICIENTS

Nurses	Correlation Coefficients
1	.891
2	.793
3	.824
4	.859

The study showed that: (1) the correlation coefficients computed for the test re-test subjects indicated substantial relationship, (2) no change was indicated in the administration of the Q-sort, (3) the code system was of use, and (4) no change was necessary in the Q-sort items.

Tabulation of data. The items were scored according to the number of the row in which they were placed by the subjects. The scores were recorded on a large ruled score sheet as shown in Appendix C. The scores were grouped according to who had done the sort. It was then possible to find the mean scored for each group and to calculate correlation coefficients.

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Statistics. Mean scores for each item in each different sort done by the patients and nurses were computed. These are shown in Appendix B. A mean score of 1.0 to 3.5 was considered to be a "negative" item; of 3.5 to 6.5 was considered to be a neutral item; and of 6.5 to 9.0 was considered to be a "positive" item. Two items whose means were three points or more apart were considered to be significantly different. Intergroup comparisons between all the patients' sorts and all the nurses' sorts and intersort comparisons between the patients' two sorts and between the nurses' two sorts were made by computing a Pearson product-moment coefficient of correlation. The significance of the coefficients of correlation was found by using the test of significance as described by Ferguson.[10]

Individual correlation coefficients were calculated for the patient-self: patient-ideal sorts and the nurse-patient: nurse-ideal patient sorts. The significance of difference between these correlation coefficients was found by using a Fisher r to z transformation and calculating confidence limits as described by Ferguson.[11]

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[10] George A. Ferguson, Statistical Analysis in Psychology and Education (New York: McGraw-Hill Book Company, Inc., 1959), p. 152.

[11] Ibid., p. 151.

IV. SUMMARY

In this chapter the methodology and technique used in the study was discussed. The method of procedure for the construction of the tool and the collection of data was included. Plans for the statistical analysis of the data were presented. In Chapter IV the interpretation and analysis of the data will be presented.

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CHAPTER IV

ANALYSIS AND INTERPRETATION OF DATA

Since the problem of this study was to gain information about the bad patient and how the nurse perceives this individual, the analysis was based on data obtained from four sorts: the patient-self and patient-ideal performed by the patients and the nurse-patient and nurse-ideal patient performed by the nurses.

The identifying information given by the patients was used in a descriptive interpretation of the data. The identifying information given by the nurses will be found in Table VI; however, in the analysis no attempt was made to relate this information to data which were obtained from the two sorts done by the nurses.

Additional interpretation of data was done by a descriptive comparison of (1) the patient-self sort and the nurse-patient sort, (2) the patient-ideal sort and the nurse-ideal patient sort, (3) the patient-self sort and the patient-ideal sort, and (4) the nurse-patient sort and the nurse-ideal patient sort.

I. STATISTICAL ANALYSIS OF DATA

Correlation coefficients for intergroup and intersort comparisons were computed. The correlation between

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the mean scores of the items for each pair of the four sorts were made by computing a Pearson product-moment correlation coefficient. (The mean scores are shown in Appendix B.) The correlation coefficients for the four sorts are shown in Table III. Individual correlation coefficients were computed for the patient-self sort: patient-ideal sort and the nurse-patient sort: nurse-ideal patient sort and are shown in Table IV.

Tests of significance for the correlation coefficients and for the difference between correlation coefficients were found and have been described in Chapter III.

TABLE III

CORRELATION COEFFICIENTS OF INTERGROUP AND INTERSORT COMPARISONS

Patient-self with nurse-patient	.237
Patient-ideal with nurse-ideal patient	.955*
Patient-self with patient-ideal	.922*
Nurse-patient with nurse-ideal patient	-.194

* Significant at the .01 level of confidence.

Analysis of intergroup comparisons. The low correlation of 0.237 between the patient-self and the nurse-patient sorts suggested that the patient described himself differently than the nurse. The high correlation

of 0.955 between the patient-ideal and the nurse-ideal patient sorts was significant at greater than the 0.01 level of confidence; that is, it could have occurred by chance only one time out of a hundred. This suggested that both the nurse and the patient described the ideal patient similarly.

Analysis of intersort comparisons. The comparison of the patient-self with the patient-ideal sorts gave a correlation of 0.922, which was significant at greater than the 0.01 level of confidence. This suggested that the patient described himself and the ideal patient somewhat alike. A negative correlation of -0.194 was found when the nurse-patient sort was compared with the nurse-ideal patient sort. This showed that the nurse described the bad patient differently than she did the ideal patient. Individual comparisons were made between the correlation coefficients of the patient-self; patient-ideal sorts and the nurse-patient: nurse-ideal patient sorts to see if the patient described himself significantly more like the ideal patient than the nurse. (See Table IV.) There was a significance of difference between the two correlation coefficients at the 0.05 level of confidence by all but one nurse. (See Table IV, Nurse 1A) Sixteen of the twenty nurse sorts were significantly different from the

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TABLE IV

CORRELATION COEFFICIENTS OF PATIENT-SELF: PATIENT-IDEAL SORT AND NURSE-PATIENT: NURSE-IDEAL PATIENT SORT

Subjects	Correlation Coefficients
Patient 1	.636
Nurse 1A	.685
Nurse 1B	.291*
Patient 2	.777
Nurse 2A	.114*
Nurse 2B	.658**
Patient 3	.620
Nurse 3A	-.663*
Nurse 3B	-.163*
Patient 4	.217
Nurse 4A	-.299*
Nurse 4B	-.489*
Patient 5	.679
Nurse 5A	.054*
Nurse 5B	-.147*
Patient 6	.658
Nurse 6A	.397**
Nurse 6B	.152*
Patient 7	.424
Nurse 7A	-.397*
Nurse 7B	.141**
Patient 8	.522
Nurse 8A	-.109*
Nurse 8B	-.005*
Patient 9	.739
Nurse 9A	-.060*
Nurse 9B	-.261*
Patient 10	.516
Nurse 10A	-.701*
Nurse 10B	-.277*

* Significant at the .01 level of confidence
**Significant at the .05 level of confidence

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patient sorts at the 0.01 level of confidence.[1] This suggested that the patient perceived himself like the ideal patient while the nurse does not.

II. DESCRIPTIVE INTERPRETATION OF THE DATA

Descriptions and comparisons of the bad patients. Although the sample was limited in size a number of comparisons could be made. A profile of the patients can be found in Table V.

The mean age for the group of bad patients was 45.5 years with a range of 22-68 years. This wide range of ages could have reflected the general population of this particular hospital or could have suggested that nurses do not identify the bad patient with a specific age range. However, Schwartz in a study of uncooperative clinic patients found that 29 out of 50 were from fifty to seventy-five years of age.[2]

There were six females identified by the nurses as bad patients and only four males. This finding was in agreement with the study by Mauksch and Tagliacozzo which

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[1] In some instances a nurse sorted on more than one patient. (See Table VI.)

[2] Doris Schwartz, "Uncooperative Patients?," The American Journal of Nursing, LVIII (January, 1958), p. 76.

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TABLE V

PATIENT'S IDENTIFYING DATA

Patient	Age	Length of Present Hospitalization (Days)	Number of Previous Hospitalizations	Diagnosis
1	22	9	2	Pelvic inflammatory disease Oophorectomy and Salpingectomy
2	36	25	25	Lupus erythematosus
3	34	7	6	Laparotomy for small bowel obstruction
4	54	7	5	Congestive heart failure
5	68	23	5	Bleeding duodenal ulcer
6	52	10	4	Bleeding duodenal ulcer
7	68	7	0	Diabetes mellitus
8	49	25	20	Laennec's cirrhosis Rheumatoid arthritis
9	46	12	3	Metastatic carcinoma
10	26	21	5	Psoriasis
Mean	45.5	14.6	7.5	
Standard Deviation	15.08	23.67	23.37	

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indicated that women seemed to fear less that they would be considered bad patients.[3]

The average length of hospitalization (14.6 days) and the average number of previous hospitalizations (7.5) suggested that these patients were familiar with the patient role and that hospitalization was not an unfamiliar event in their lives.

An attempt to classify the diagnoses of these patients showed that all but two were afflicted with a chronic illness. This finding suggested two possibilities. Nurses' attitudes to patients with chronic illness would be such that they were more prone to identify these individuals as bad. This could be of particular significance when the care given by the nurse was ineffective in helping the patient. As Schwartz has pointed out, patients who made the nurse feel ineffective were labeled as an uncooperative patient.[4] Another possibility that could have explained the patient's behavior in relation to his illness is the effect of the illness on their own personality needs.

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[3] Hans O. Mauksch and Daisy L. Tagliacozzo, The Patient's View of the Patient Role, Department of Patient Care Research, Presbyterian-St. Luke's Hospital, Part I (Chicago: Presbyterian-St. Luke's Hospital, 1962), p. iv.

[4] Schwartz, op. cit., p. 75.

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TABLE VI

NURSE'S IDENTIFYING DATA

Nurse	Position	Age	Education	Months in this Institution
1A	Asst. Head Nurse	23	Diploma	20
1B*	Team Leader	35	Diploma Degree	2
2A	Head Nurse	45	Diploma	34
2B*	Team Leader	26	Diploma	2 weeks
3A	Staff Nurse	24	Diploma	1
3B*	Team Leader	37	Diploma	2 weeks
4A	Head Nurse	47	Diploma	40
4B	Team Leader	32	Diploma	18
5A	Asst. Head Nurse	24	Diploma	12
5B	Staff Nurse	26	Diploma	4
6A	(Same as 4A)			
6B*	(Same as 1B)			
7A	(Same as 4A)			
7B*	(Same as 3B)			
8A	(Same as 4A)			
8B	Staff Nurse	28	Degree	2
9A	Asst. Head Nurse	24	Diploma	2
9B	(Same as 4B)			
10A	Head Nurse	35	Diploma Degree	12
10B	(Same as 8B)			

*Registered nurses enrolled in Graduate Nurse program at the University of Colorado

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TABLE VI (continued)

Nurse	Months On This Floor	Months in This Position	Year of Graduation
1A	20	6	1961
1B	2	2	1951 1962
2A	24	22	1940
2B	2 weeks	2 weeks	1958
3A	1	1	1961
3B	2 weeks	2 weeks	1949
4A	40	4	1938
4B	1	18	1953
5A	12	5	1960
5B	4	4	1959
6A	(Same as 4A)		
6B	(Same as 1B)		
7A	(Same as 4A)		
7B	(Same as 3B)		
8A	(Same as 4A)		
8B	4	4	1957
9A	20	3	1960
9B	(Same as 4B)		
10A	12	2	1949 1957
10B	(Same as 8B)		

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Descriptions and comparisons of the patient-self sort and nurse-patient sort. The positive items agreed upon by both nurses and patients indicated that the patient was afraid, anxious, sick and very concerned over their health. However the patient also saw himself as interested in getting well while the nurse was not so sure of this. The patient did not feel he was an attention seeker or was unwilling to help himself but the nurses disagreed with these statements. The nurses felt that these patients were hard to please, irritating, unhappy, but were polite.

Although the nurses' responses indicated that they had some understanding of the feelings of these patients they still seemed to reflect their own feelings of ineffectiveness by agreeing that the patients were not meeting the nurses' expectations of the patient role. However, the patients seemed to fit into the patient role by agreeing that they tried to please, were appreciative and curious. This finding suggested that the patients did not see themselves as bad patients.

Descriptions and comparisons of the patient-ideal and nurse-ideal patient sorts. Generally the nurses and patients agreed completely on what was the ideal patient. There were no points of disagreement between the two sorts. The ideal patient was seen as understanding, appreciative, sick, cooperative, accepting of his

illness, interested in getting well, accepting of treatment and helping himself. The nurses and patients agreed that the ideal patient was not an attention seeker, chronic complainer, irritating, unwilling to help self, selfish, demanding, a criticizer, or hard to please. Both nurses and patients also agreed on what constituted non-preferred behavior for the patient.

Descriptions and comparisons of the patient-self and patient-ideal sorts. When comparing themselves to the ideal patient the patients felt they were very similar to the ideal patient. The patients felt both they and the ideal patient were interested in getting well, trying to please, and helping themselves. They also agreed that both were very concerned over their health, appreciative, sick, and friendly. The patients saw themselves as more afraid and curious than the ideal patient, while the ideal patient was more understanding, cooperative, accepting of his illness and treatment than the bad patient. These items which the patient saw as not describing himself or the ideal patient were attention seeker, chronic complainer, unwilling to help self, demanding, and gossipy. Although not significant some patients felt they were more shrewd, irritating, selfish, hostile, grouchy, hard to please, and a nuisance than the ideal patient. The patient felt he was less likely to

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die than the ideal patient and that he was not a "gold-brick" or helpless.

The bad patient identified himself with the ideal patient and saw himself conforming to his own idea of the ideal patient role. This suggested that the patient saw no need to alter his behavior since he was convinced that his behavior was directed at being an ideal patient.

Descriptions and comparisons of the nurse-patient sort and nurse-ideal patient sort. The nurses did not identify any characteristics of the bad patients as being like the ideal patient. The two main points of difference between the bad patients and the ideal patient were that the bad patient was irritating and hard to please. These items were found to be least descriptive of the ideal patient. Other points of difference showed the nurse felt the ideal patient was cooperative and accepted his illness and was not an attention seeker or demanding. Apparently the most important variables in identifying a patient as bad or ideal were the labels applied to the patient as an irritator and hard to please. These two items suggested the possibility that the nurses felt they had little effect on helping the patient conform to the nurses' idea of the patient role.

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III. SUMMARY

A statistical analysis was made of the data obtained from the four sorts: the patient-self, patient-ideal done by the patients and the nurse-patient, nurse-ideal patient done by the nurses. Correlation coefficients for the patient-ideal: nurse-ideal patient sorts and the patient-self: patient-ideal sorts were significant at the 0.01 level of confidence. Individual correlation coefficients between the patient-self: patient-ideal sorts and the nurse-patient: nurse-ideal patient sorts were computed. Sixteen of the twenty nurse sorts were significantly different from the patient sorts at the 0.01 level of confidence and all but one nurse sort was significantly different at the 0.05 level of confidence.

Descriptive interpretations of the patients selected for the study and for the intergroup and intersort comparisons were made.

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CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

I. SUMMARY

The problem of this study was to gain information about the bad patient and how the nurse perceives this individual. The information studied was: (1) the nurse's perceptions of the bad patient, (2) the patient's perceptions of himself, and (3) the nurse's and patient's perceptions of the ideal patient. The primary purpose of the study was to obtain objective data about the perceptions of the patient and nurse. Another purpose was to identify differences and similarities between bad and ideal patients as well as similar variables among bad patients.

A review of the literature showed that the patient role in the hospital has specific features to which the individual is expected to conform. Those individuals who do not fit within this role are labeled as bad patients. Numerous factors may influence the behavior of the patient in the hospital. Also of importance was that nurses have definite ideas of what constituted the good and bad patient.

The Q-sort technique was used in this study. The Q-sort items were drawn from literature describing the

bad and ideal patient. The fifty items were sorted by ten patients and thirteen nurses selected from the medical-surgical population of a general hospital. Both groups used the same set of items to describe the patient and the ideal patient. The nurses sorted the items twice; first, describing the actual patient, and second, describing the ideal patient. The patients also sorted the items twice; first, describing themselves, and second, describing the ideal patient.

The sorts were converted to mean scores for the individual items and then compared for agreement. This was done by computing a Pearson product-moment correlation coefficient. Descriptive comparisons of the four sorts were obtained by using the mean scores to indicate positive and negative items as well as significant differences between items.

The correlation coefficients were greater than the 0.01 level of confidence for the patient-self: patient-ideal sorts and the patient-ideal: nurse-ideal patient sorts. A significance of difference greater than the 0.01 level of confidence was found in the sorts of sixteen of twenty nurses sorts between the nurse-patient: nurse-ideal patient sorts and the patient-self: patient-ideal patient sorts.

A description of the bad patients indicated that no particular age was characteristic of this group but

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that more females than males were identified as bad patients. The patient's illness, a chronic disease, necessitated frequent hospitalizations and familiarity with the patient role.

A descriptive comparison of the intergroup sorts indicated that patients and nurses agreed as to what constitutes the ideal patient; however, there was disagreement as to what was characteristic of the bad patient. The patients saw themselves as being very similar to the ideal patient while the nurses could find no points of agreement between the bad and ideal patient.

II. CONCLUSIONS

On the basis of the data obtained in this study, the following conclusions were made.

1. A descriptive comparison of the patients selected for this study indicated that there was no age group which characterized the bad patient. A majority of the patients were females. The mean length of hospitalization (14.6 days) and the average number of previous hospitalizations (7.5) indicated that these patients had prior opportunity to become familiar with the hospital environment and the patient role. The preponderance of chronic illness in the sample suggested that the behavior of these patients was affected by

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their illness or that nurses' attitudes toward chronic illness affected their perceptions of these patients.

2. The descriptive comparison of the patient-ideal sort and the nurse-ideal patient sort pointed out that nurses and patients agreed on what constituted the ideal patient role in the hospital.

The correlation coefficient of the patient-ideal sort and the nurse-ideal patient sort was 0.955. This significant correlation indicated that patients and nurses agree as to what constitutes the ideal patient role. This also suggested that the patient is aware of what behavior is expected of him in the hospital environment.

3. A descriptive comparison of the patient-self sort and the patient-ideal sort indicated that the patient identified himself with the ideal patient and did not see himself as a bad patient.

The correlation coefficient of 0.922 between the patient-self sort and the patient-ideal sort was of significance. This indicated the bad patient sees himself as conforming to the ideal patient role. The patient did not see himself as a bad patient and felt his behavior was satisfactory in the patient role.

4. The comparison of the nurse-patient sort and the nurse-ideal patient sort identified two main differences between the bad and the ideal patient. These two

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differences, irritating and hard to please, suggested that nurses felt they were not effective in helping the patient.

5. A descriptive comparison of the patient-self sort and the nurse-patient sort showed that although the nurse had some understanding of the feelings and attitudes of the patient she still saw him as being a bad patient.

6. Sixteen of the twenty nurse sorts were significantly different from the patient sorts when the patient-self: patient-ideal correlation coefficient was compared with the nurse-patient: nurse-ideal patient correlation coefficient. This indicated that the patient perceived himself significantly closer to the ideal patient than did the nurse.

III. RECOMMENDATIONS

On the basis of the data obtained in the study the following recommendations are made.

1. That the Q-sort items used in this study be performed by members of the medical care team, other than nurses, to determine if similar statistical relationships exist.

2. That longitudinal studies be made to determine when a patient is labeled as bad and at what point, if any, this label is removed.

3. That further exploration be made of the relationship of chronic illness and the bad patient.

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4. That an investigation be devoted to exploring the behavior of the nurse toward the bad patient and the effect of her attitudes toward this patient on the nursing care she gives.

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APPENDIX A

Copies of Letters

Doctor _____,

As a graduate student at the University of Colorado School of Nursing I am doing a research study which involves an examination of patients who are considered by nurses to be "problem patients". It is hoped that the results of this study will help nurses understand and care for these patients more effectively.

Your patient, _____, has been selected for this study. This patient will be asked to describe himself and also how he sees the ideal patient. Nurses also will be asked to describe these patients.

All the information gathered will be kept confidential and permission will be secured from the patient before proceding.

If you give permission for your patient to participate in this study please sign in the blank provided below. Thank you for your assistance.

Sincerely,

Reeda Owens, R.N.

_____

1364 Xanadu #3
Aurora, Colorado
May 2, 1964

NAME
STREET
ADDRESS

Dear Miss _____:

This letter is to confirm our conversation regarding my thesis on problem patients.

Using Q-sort methodology selected charge nurses and team leaders will be asked to sort on a specific problem patient and on the ideal patient. The problem patients selected will be asked to do a self sort and an ideal sort. Prior to this a signed letter of permission will be obtained from the patient's attending physician.

The names of the nurses and patients and the name of the hospital will be kept confidential.

I will be happy to share the results of this study with you and will inform you of the completion of this study.

Sincerely yours,

Reeda Owens

APPENDIX B

Q-Sort Items with Mean Scores from the Four Sorts

Q-SORT ITEMS WITH MEAN SCORES FROM THE FOUR SORTS: PATIENT-SELF, PATIENT-IDEAL, NURSE-PATIENT, NURSE IDEAL-PATIENT*

	Items	Mean Scores			
		P.S.	P.I.	N.P.	N.I.P.
1.	Submissive	4.70	5.30	4.30	4.55
2.	Attention Seeker	2.70	1.80	6.35	2.70
3.	Shrewd	3.80	3.50	4.95	4.30
4.	Chronic complainer	2.20	1.80	4.55	2.50
5.	Understanding	6.30	6.80	4.15	7.05
6.	Friendly	6.50	6.60	5.05	5.95
7.	Nuisance	4.30	2.80	4.35	3.55
8.	Going to die	3.10	4.40	4.40	4.40
9.	Lonely	5.10	4.70	5.85	5.00
10.	Childish	3.70	4.30	5.70	3.65
11.	Seriously ill	5.70	5.10	4.95	5.55
12.	Good	5.10	5.40	4.80	5.40
13.	Quiet	5.10	5.70	5.00	5.40
14.	Irritating	4.20	3.10	6.50	3.50
15.	Unwilling to help self	1.80	2.30	4.90	3.25
16.	Tries to please	7.10	7.10	5.30	5.90
17.	Very concerned over health	7.10	6.90	6.90	4.85
18.	Selfish	3.60	2.90	5.40	2.55
19.	Appreciative	7.40	7.50	4.90	6.95
20.	Pleasant	6.00	6.30	4.55	6.45

Items	Mean Scores P.S.	P.I.	N.P.	N.I.P.
21. Demanding	3.50	2.40	5.75	2.75
22. Polite	6.00	6.20	7.05	6.10
23. Afraid	6.80	5.70	7.25	5.60
24. Anxious	6.30	5.50	6.80	5.45
25. Happy	4.80	5.40	3.50	6.10
26. Suspicious	4.00	3.80	5.15	4.10
27. Criticizes	3.80	3.00	4.85	3.10
28. Sick	6.70	6.50	6.40	6.75
29. Cooperative	6.30	7.30	4.40	7.75
30. Accepts illness	6.00	6.90	3.80	7.60
31. Hostile	3.60	3.40	4.50	3.95
32. A "goldbrick"	2.60	4.30	3.60	3.50
33. Almost well	4.60	4.70	4.45	4.70
34. Obedient	5.40	6.30	4.60	5.80
35. Unhappy	5.90	4.40	6.85	4.60
36. Cheerful	5.60	6.70	3.60	6.05
37. Interested in getting well	8.30	7.70	5.20	7.55
38. Accepts treatment without complaining	5.60	7.40	4.35	7.00
39. Grouchy	4.50	3.30	5.55	3.75
40. Nice	5.40	5.80	5.30	5.45
41. Helps self	7.40	7.50	4.75	7.05
42. Gossipy	3.50	3.50	4.20	3.60
43. Untidy	4.50	3.90	4.90	4.25
44. Timid	4.00	5.00	4.00	5.00

	Items	Mean Scores P.S.	P.I.	N.P.	N.I.P.
45.	Curious	6.50	5.60	5.05	5.75
46.	Asks too many questions	6.00	4.30	3.95	3.65
47.	Courageous	4.00	6.30	4.30	6.65
48.	Hard to please	4.60	2.80	6.55	3.00
49.	Neat	5.00	5.60	4.85	6.10
50.	Helpless	3.20	4.50	3.60	4.50

*This mean score of each item in the four sorts is listed. The scores within the range of 1.0 to 3.5 are considered "negative" items; the scores within the range of 3.5 to 6.5 are considered neutral; and the scores within the range 6.5 to 9.0 are considered "positive".

APPENDIX C

Data Sheet, Score Sheet, and Formulas

SCORE SHEET

Subjects				Items 1 50
1				
2				
3				
. . . . . N				
Mean Scores				

DATA SHEET

Code # _____

Sort _____

Col. 9 __ __

Col. 8 __ __ __

Col. 7 __ __ __ __ __ __

Col. 6 __ __ __ __ __ __ __ __ __

Col. 5 __ __ __ __ __ __ __ __ __ __

Col. 4 __ __ __ __ __ __ __ __ __

Col. 3 __ __ __ __ __ __

Col. 2 __ __ __

Col. 1 __ __

Code # _____

Sort _____

Col. 9 __ __

Col. 8 __ __ __

Col. 7 __ __ __ __ __ __

Col. 6 __ __ __ __ __ __ __ __ __

Col. 5 __ __ __ __ __ __ __ __ __ __

Col. 4 __ __ __ __ __ __ __ __ __

Col. 3 __ __ __ __ __ __

Col. 2 __ __ __

Col. 1 __ __

FORMULAS

Pearson Product-Moment Coefficient or Correlation

$$r = \frac{\Sigma xy}{\sqrt{\Sigma x^2 \Sigma y^2}}$$

Significance of a Correlation Coefficient

$$t = r \sqrt{\frac{N - 2}{1 - r^2}}$$

Significance of Difference Between Correlation Coefficients

$$\text{Standard error of } z_r = \frac{1}{\sqrt{N - 3}}$$

Standard error of $z_r \pm 1.96$ = .05 level of confidence

Standard error of $z_r \pm 2.58$ = .01 level of confidence

APPENDIX D

Instructions to Subjects

INSTRUCTIONS TO SUBJECTS

You are asked to describe how you/ the patient act or feel in the hospital. Each of the cards has on it words that refer to the actions and feelings of patients in the hospital.

Now separate the cards into two piles. In one pile place all the cards that best describe yourself/ the patient in the hospital. Into the other pile place the cards which least describe yourself/ the patient. Now take the pile which best describes yourself/ the patient. Select the eleven cards that best describe yourself/ the patient. Place these cards in rank order, the first one being the item which most describes yourself/ the patient, the next item which is second in describing yourself/ the patient, and so on.

After sorting the cards which best describe yourself/ the patient take the pile of cards which least describe yourself/ the patient. Select the eleven cards that least describe yourself/ the patient. Place these cards in rank order, the first one being the item which least describes yourself/ the patient, and so on.

When you have finished take the remaining cards and arrange them in three piles of 9, 10, and 9 cards. The first pile of nine should best describe yourself/ the patient; the second pile of ten should be neutral items;

and the last pile of nine should least describe yourself/ the patient.

In the first sort you were asked to arrange the cards as to how they described yourself/ the patient. This time you are asked to sort the cards as you feel they describe the ideal patient. Follow the procedure as before but sort according to how the items best and least describe the ideal patient.